

Kentucky Medicaid  
DSH Survey – Audit Project  
Frequently Asked Questions

1. Which Medicare cost report do I use the as submitted or final.

Response: Use the best information available. If audited Medicare cost reports are available, they should be used to complete the survey. If the final Medicare cost report is not available, the Medicare as filed cost report can be used.

2. Which Medicaid PCL do I use – should I use the PCL that was filed with my cost report?

Response: No, DMS will send you an updated Kentucky Medicaid FFS PCL. You may have already received yours at the training, but as soon as we receive them they are being mailed to providers.

3. Should the information on the survey be reported in the state's DSH year or the provider's FYE (Cost Report year)?

Response: The information reported on the survey should contain information based on the cost reporting periods that fall throughout the DSH year. **The entire cost report FYE should be reported.** The cost reporting periods were programmed into the survey, so we encourage the use of the drop down feature to select your provider, the cost report periods will populate automatically. Providers can check their cost reporting period for accuracy.

4. Do I report all or sample FFS and managed care payments?

Response: All payments related to the cost reporting periods should be reported. Sampling or estimating any data on the survey is not allowed.

5. Should I include all cost to charge and fixed fee charges and payments from the Medicaid FFS PCLs?

Response: Yes

6. Is there any difference between the 2005 and 2006 survey?

Response: No, but when you select your hospital from the drop down feature different cost reporting periods will populate based on the DSH year being audited.

7. What needs to be included for questions number 7 from the DSH Survey Submission Checklist (supporting documentation used to complete Medicare Allowed Amount on cross-overs)?

Response: DMS is working on providing crossover claims data to each provider. When this data is available it will be mailed to providers.

8. Should KHCP days be included on the DSH survey?

Response: Yes, these are your DSH indigent care days. However, make sure all uninsured patient days reported satisfy the CMS definition of uninsured.

9. Do I need to fill out survey if I did not receive DSH payments during the DSH year?

Response: No, if you did not receive DSH payments during the DSH year being audited then the survey is not required.

10. Will a time extension be granted if I can't get necessary data such as Out of State data by the appropriate due date.

Response: Extensions will be granted based on the volume of available surveys that have been submitted by other providers. Based on early conversations with providers, we believe there will be surveys submitted by the June 30<sup>th</sup> deadline, therefore, making extensions for other providers likely.

11. Do I need data from my PCLs?

Response: Yes, we encourage you to utilize the Medicaid paid claims listings recently provided for the in-state FFS columns of the survey. We are currently working on in-state MCO and Crossover data, and will provide that data as soon as it becomes available.

12. Where do I get the remaining data? (i.e., the out-of-state and uninsured data)?

Response: A provider can utilize several data strategies. A.) the provider can contact the out-of-state payer and request paid claims data, or B.) the provider can request that their IT department pull data from their system based on an out-of-state indicator, or C.) if out-of-state patient data is available, remittance advice documentation may also be helpful.

The uninsured data has to come from the provider's internal accounting system. This typically involves getting their IT department involved to pull data in order to complete Exhibit A, and B.

13. Should discounts be netted from gross charges?

Response: All gross charges should be reported in the survey.

14. Should Exhibit B be including all self-payments?

Response: Exhibit B should include all insured and uninsured self-payments.

15. Should non-covered charges from the PCL be included in the survey?

Response: No.

16. How should professional fees be handled?

Response: For Schedule D and E – professional fees should not be included in the charges for hospital inpatient or outpatient.

Note: professional fees are not included in the hospital-specific DSH limit therefore not reported throughout the survey in data used to arrive at the DSH limit.

However, for Exhibit B – professional charges for I/P and O/P should be reported in the separate column in order to accurately calculate the collections attributed to the hospital's uninsured. Reporting professional charges on Exhibit B will apportion the cash collections between the services.

17. How should crossover bad debt payments be reported? Can the cost report W/S E, Part I, be used?

Response: Yes, if you have a break-out of your cross-over bad debts on your cost report including any rehab or psychiatric units. If you can't get it from the cost report you can use your own records and supply documentation to support it **or** you can allow us to provide a calculated bad debt number based on the cross-over claim data.

18. On Exhibit A, what do patient identifier and routine days of care mean?

Response: Patient identifier is the internal patient account number and routine days of care are the patient length of stay.

19. How should I get started on my survey?

Response: We have shared with KHA a document to route to hospitals providing basic steps to get started. If you need a copy of that reference document, please contact Myers and Stauffer and we will email you a copy.

20. If a cost report FYB and FYE falls within two DSH years is the same data reported on both surveys.

Response: It is possible that a cost report period used for the 2005 survey will also fall within the 2006 DSH survey period, therefore the 2006 survey will have identical data as the 2005 survey for one of the cost report periods. Providers only need to include the data for a given cost report period on one of the survey files. The key is to ensure that each cost report, as populated on the DSH survey based on the DSH year and your FYE, is reported on one of the survey templates.

21. Is my cost report being audited?

Response: No

22. On Exhibit B, should the Self pay payments be reported on the DSH year?

Response: No, Exhibit B should be reported on the cost report periods.

23. The **appeal** settlement money that was recently paid out should those receipts be included as payments on the 2005 or 2006 survey?

Response: DMS is treating the DRG and OP appeals settlements prospectively, therefore, those payments should not be included on the 2005 and 2006 survey.

Note: the routine settlement payments and collections made when an outpatient cost report settlement is completed should be reported as a settlement payment (see Note E., schedule D).

24. Please provide an example of a subsidy.

Response: Anything received to subsidize uninsured patient care. These vary from state to state and are rare – would come from state or county, typically.

25. How should I sort my data on Exhibit A?

Response: Exhibit A should be sorted by service indicator and then by revenue code this will enable you to group your charges on Section D of the survey.

Basically service indicator should separate the data between inpatient and outpatient. Once the data is separated in that fashion, the inpatient days and charges should transfer to the Schedule D for uninsured. Once separated by revenue code – all the same revenue codes can be summed up and transferred through the provider's crosswalk into the appropriate cost center on the survey. This process is identical to your Medicare cost reporting principles.

FYI- This process can also be followed to obtain your out-of-state data for out-of-state Medicaid, out-of-state MCOs, and out-of-state Crossovers. Once your IT department pulls all out-of-state patients, you should be able to sort and categorize patients into the various payers needed (out-of-state Medicaid, out-of-state MCO, and out-of-state crossovers). Once you've separated by payer, then following the same routine by sorting by service indicator, then by revenue code....summing by revenue code, then using the crosswalk to ultimately report data in appropriate cost centers on Schedule E of the survey.

26. What is required on Exhibit B-1?

Response: Exhibit B-1 is not required and is only used if a provider doesn't have insurance status on old records.

27. If I can't obtain my out-of-state PCL records, can I use my remittance advices as source documentation for Section E of the survey?

Response: Yes, but we would need a summary worksheet or summary log submitted with the survey. Please keep available all the source documentation used to create the summary in the event it is requested during audit.

28. If I don't have detailed information, can I spread my charges or estimate?

Response: No CMS has specifically said that "spreading" charges or estimating is not allowed. The data provided must be traceable to detailed patient level data.

29. How do I handle cash collections through an external collection agent?

Response: The actual cash remitted back to the provider via the third party collector is the amount to be reported on Exhibit B.

30. What is considered a self pay cash collection for Exhibit B?

Response: Any payment received by the patient (i.e., deductible, copay, coinsurance, private pay for insured or uninsured).

31. Are Exhibit A, B, and B-1 supposed to allow data entry – are these a template or merely an example data layout?

Response: These exhibits were not designed for data entry. These are for illustrative purposes of how a provider may pull data from their system. This detailed information must be submitted along with the survey. Each provider may report this differently, although these basic data elements as illustrated in the exhibits are required. Please note – providers should follow the formula methodology outlined in the exhibit for calculating the hospital uninsured collections. By pulling up the electronic file, a provider can see the formula in the last column and mirror that methodology using their created exhibit and relevant columns.

32. Please confirm, for SFY 2010, DMS will be auditing 2007 cost report information, in SFY 2011, DMS will be auditing 2008 cost report information.

Response: Yes, that's correct; however, it may still include more than one cost report each year depending on the provider's FYE. Cost reports are needed to cover the entire DSH SFY. Keep in mind, that once cost report information is reviewed in a prior year, it won't be reviewed again the next year.

33.If a patient is totally **self-insured**, do they appear on Exhibit A and Exhibit B for the survey?

Response: Yes, a patient that is self-insured with no health insurance or other third party coverage receiving services defined as inpatient or outpatient hospital services consistent with services under the Medicaid state plan would be considered as uninsured.

The patients should be included on Exhibit A and Exhibit B (self-insured charges and relevant data is reported on Exhibit A, and all payments received related to the self-insured patient's service is reported on Exhibit B).

34.Which revenue code crosswalk should be used to report the data in the appropriate cost center: a.) the current crosswalk, or b.) the crosswalk used to originally complete the relevant cost report periods (i.e., crosswalk in place during 2005 / 2006 periods)

Response: Providers should utilize the crosswalk in place at the time of completion of the cost reports, if available. Only if the 2005/ 2006 crosswalk can not be located should a provider use the current cross walk to group data to the cost centers on the survey. If the current crosswalk is used, a note in the survey submission should be provided that describes why the original cross walk was not utilized.

35.Can I add additional ancillary cost centers on Schedule D?

Response: Yes, all data should reconcile, additional lines are provided to ensure your data can be fully reported. These cost centers are consistent with your Cost Report Worksheet C – Part 1.

36. Do I include the zero paid nursery days from the PCL on Schedule D?

Response: Yes, zero paid nursery days are included, along with the nursery per diem cost on Schedule D. These are Medicaid eligible patients that are receiving an approved State Plan service, so their cost is part of the hospital-specific DSH limit.

Note – just to clarify, this is different than the non-covered charges on the PCL. Those are NOT included on Schedule D – because they are not an approved state plan service and should not be included in the DSH limit.

37. Will my Schedule D uninsured column agree in total to the Exhibit A?

Response: No, only report the **hospital non-professional charges** on Sch. D. All will be listed on the Exhibit A but they will be sub-totaled and only the hospital non-professional piece will be brought to Sch. D. For instance, the provider should not carry over the RHC line items reported on Exhibit A, to the Schedule D.

38. In the “insured” column on Exhibit B – should we include co-pay and deductibles?

Response: Yes, it would include any payment from the patient.

39. Can I submit consolidated Financial Statements – if the notes detail the charity amount for the hospital?

Response: Yes, as long as we can identify the charity amount related to the hospital on the survey.

40. On Section C of the survey, if I use my Medicare G-3 to complete the section C – the G-3 Medicare schedule has contractals with bad debt included. Can I back out the bad debt and provide supporting documentation?

Response: Yes, bad debts can be removed from contractals to complete section C of the survey. Please provide documentation of the removal.

41. Is it necessary to split out I/P and O/P on self pay – the cost to charge ratios are the same for ancillary services for both I/P and O/P?

Response: Yes – These should be reported separately.

42. For self pay, can we include charges and related expenses for Ambulance and DME service lines?

Response: According to CMS, Ambulance and DME are not considered hospital services – therefore should not be included in the survey to determine the hospital-specific DSH limit.

43. How should additional cost centers on the PCL be treated if they didn't have their own cost to charge ratio on Sch. C?

Response: Those should be treated consistent to how they were treated on their Medicare cost report then provide support for where those charges are reported.

44. How should outpatient settlement payments be handled? Reported for the cost report year, or reported in the year received / paid? Should you include the payment made when filing the cost report?

Response: When an outpatient settlement is completed and a payment is either received or paid, those payments should be reported in the year that the payment relates to (i.e., accrual basis, not cash basis). Yes, those interim payments made when filing the cost report should be reported since the payment is not reflected in the PCL.

45. Is home health and ambulance on Schedule C as non-hospital?

Response: Yes, report these in the non-hospital column.

46. Is the survey due date still June 30<sup>th</sup>?

Response: DMS has extended to survey **due date to July 8, 2009**. We anticipate the crossover and Passport / MCO data will be mailed to providers the week of June 22, 2009.